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Framework to strengthen implementation of the WHO European Action Plan to Reduce the Harmful Use of Alcohol (EAPA), 2022 – 2025

Towards a WHO European Region free from harm due to alcohol

Content to be inserted in final version

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Contents

Introduction

This framework is guided by the overall vision of a WHO European Region free from harm due to alcohol. For the duration of its implementation period of 2022-2025 it envisions a WHO European Region with considerably reduced morbidity and mortality and ensuing social consequences because of alcohol consumption.

We know how to achieve this. The means are described in the *Global Strategy to Reduce the Harmful Use of Alcohol* (WHO, 2010) which was adopted by a resolution (WHA63.13), agreed by the 193 Member States of WHO at the sixty-third session of the World Health Assembly in 2010. The *European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020* (EAPA), which was endorsed by the 53 European Member States in 2011, provides more tailored guidance regarding targets and actions for the European Region (WHO, 2012). Alcohol control measures also play a key role in the priorities laid out in efforts to achieve the global goal of a 25% relative reduction in premature mortality from NCDs by 2025 agreed in 2015 by the World Health Assembly. As part of this, the WHO NCD Global Monitoring Framework was adopted, which includes the voluntarily target of a 10% relative reduction in the harmful use of alcohol, as appropriate, within the national context (WHA66.10) (WHO, 2013a). In addition, the forthcoming *Global Alcohol Action Plan (2022–2030) to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority* (WHO, 2022a) will be considered by the Seventy-fifth World Health Assembly in May 2022, following the 150th session of the WHO Executive Board in January 2022.

While in some areas there has been progress, the powerful tools that we have to reduce alcohol consumption and associated harms are not being used to their full potential. Since the adoption of the *European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020* (EAPA) (resolution EUR/RC61/R4) by the WHO Regional Committee for Europe at its 61st session (RC61), 32 countries have changed or adopted a national alcohol policy or strategy. Barriers to implementation include limited or reduced financial and human resources, opposition, including lobbying and legal actions by economic operators, the complications caused by trade agreements and cross-border operation of marketing activities, including traditional and digital advertising and international trade. Of the 10 EAPA action areas, only three have achieved relatively high implementation scores: (i) drink–driving countermeasures; (ii) leadership, awareness and commitment; and (iii) actions to tackle unrecorded (informal or illicit) alcohol. Other areas received moderate or low scores (WHO, 2021a). The most high-impact and cost-effective policies, such as the three WHO “Best Buys”, namely raising the price of alcohol through excise and other duties, restricting availability, and restricting or banning alcohol marketing, are implemented at a level that leaves much space for improvement. Pricing policies are the worst-performing policy area in the Region (WHO, 2019a, 2021a), and there is evidence that more use could be made of taxation policies to reduce harms due to alcohol consumption across the Region (Neufeld et al. 2022).

This framework will ensure that no Member State is left behind, providing the opportunity for all States parties to gain from innovation, share experience and together face emerging (and cross-boundary) challenges in the area of alcohol policy.

We know what we will gain if we succeed. Alcohol has been identified as a causal factor for more than 200 diseases, health conditions and injuries. Alcohol is classified as a Group 1 human carcinogen by the International Agency for Research on Cancer, being causally linked to seven types of cancer. Like COVID-19, alcohol harm exacerbates existing health inequalities; evidence shows that similar levels of alcohol consumption are associated with a more damaging impact on the health of more deprived individuals and their families compared to wealthier drinkers. There is a robust evidence base for alcohol control measures to reduce alcohol consumption and harms, as well as broader health inequalities and there is clear guidance on which measures can be considered as cost-effective, meaning that they reduce the most harm per resources invested (WHO, 2017a). From 2010 to 2017, largely due to policy actions, adult alcohol consumption, alcohol-attributable deaths and disability-adjusted life years decreased in 67% of Member States, mainly in the east of Europe and central Asia. There are substantial returns on investment from alcohol control measures, with significant productivity gains and savings to health and social care (OECD, 2021). We also know that effective public health policies in relation to alcohol can gain support from the majority of populations, and that this support can ensure their successful implementation, with health and social improvements as a result.

We know what we stand to lose if we fail. Alcohol consumption and the burden of disease it brings present some of the greatest health and societal challenges faced by Member States in the WHO European Region. Globally, the European Region has the highest level of alcohol per capita consumption and the highest proportion of drinkers. One in every 10 deaths in the Region each year is caused by alcohol, amounting to almost 1 million in total, and many of these deaths occur at a very young age. As was laid out in the *Final Report on Implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020*, endorsed by WHO Regional Committee for Europe in September 2020 (WHO, 2020a), although the target of a 10% relative reduction in harmful use of alcohol by 2025, has been achieved ahead of time, this has been due to important decreases in consumption in eastern European and central Asian countries. Over the same period, total alcohol per capita consumption increased in 33% of Member States. The forthcoming *Global Action Plan (2022–2030) to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority* (WHO, 2022a), which will be considered by the Seventy-fifth World Health Assembly in May 2022, includes a new ambitious target of at least a 20% relative reduction in the harmful use of alcohol by 2030. Failure to act to implement evidence-based alcohol control policies across the WHO European Region will make this difficult to achieve.

We have the mandate to act. The strategic actions will be part of a comprehensive approach and will align with the European Programme of Work, 2020–2025 (WHO, 2020b) through measures aimed at reducing alcohol-attributable harms and health inequalities, leaving no one behind. The

strategic actions will also align with actions to address alcohol consumption set under core priority 3 – promoting health and well-being – in the regional plan for implementation of Programme budget 2022–2023 in the Region, adopted by Member States at RC71 in 2021 (EUR/RC71/12). The framework will support the realization of commitments made under the United Nations 2030 Agenda for Sustainable Development, including achievement of targets 3.4 and 3.5 of the Sustainable Development Goals (United Nations, 2022), and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025 (WHO, 2016). The framework will also link to the WHO-led SAFER initiative (WHO, 2022b) and the forthcoming *Action plan (2022–2030) to effectively implement the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority*, which will be considered by the Seventy-fifth World Health Assembly in May 2022, following the 150th session of the WHO Executive Board in January 2022 (WHO, 2022a). The framework will also align with the proposals of the WHO Regional Director for Europe's Advisory Council on Innovation for Noncommunicable Diseases (NCD), established in 2020; the pan-European movement United Action Against Cancer, and its signature solutions; and other relevant global and regional action plans, strategies and frameworks, including Europe's Beating Cancer Plan of the European Union (European Commission, 2021).

In January 2019, two preliminary consultations were held with Member States and civil society organizations. These consultations called for further strengthening of implementation of the EAPA at country level in the least implemented areas. In October 2019, the WHO Regional Office for Europe (WHO/Euro) convened a regional consultation with Member States to determine the way forward. The outcome of the consultations highlighted the need to develop a framework for action focusing on the implementation of priority areas, including the "Best Buy" policies that currently have a low implementation rate, in order to further reduce alcohol consumption and attributable harm (WHO, 2019b, 2020e). This need was further confirmed in the *Final Report on Implementation of the European Action Plan to Reduce the Harmful Use of Alcohol 2012–2020*, presented at RC70 (document EUR/RC70/8(A)) (WHO, 2020a).

Vision and Values

This framework envisions a WHO European Region with considerably reduced morbidity and mortality from alcohol consumption and ensuing social consequences, with a long-term strategic ambition for a SAFER European Region free from harm due to alcohol (WHO, 2021a).

The following values underpin this framework:

1. Gender sensitivity and a commitment to reducing health inequalities - while overall male consumption of alcohol may be up to four times as much as that of females, the promotion of alcohol consumption as a social norm increases potential risks to health and well-being for all groups in society, including women and disproportionately harming all groups who are socially and economically disadvantaged.

2. A prioritization of public health interests – recognizing the guiding principles included in the *Global Strategy* (WHO, 2010), emphasising that public policies and interventions to prevent and reduce alcohol-related harm should be formulated and guided by public health interests and based on clear public health goals and the best available evidence – with no interference from economic operators.

3. The protection of children – recognizing that children and young people are especially at risk of harm from exposure to alcohol marketing and that this exposure affects the onset of alcohol use, as well as frequency of drinking and drinking patterns. This undermines the right to health of children as defined in *The United Nations Convention on the Rights of the Child.*

4. Leaving no one behind – stressing the importance of ensuring that all countries in the Region are helped to achieve this goal, which is particularly important given the cross-boundary issues of alcohol control, and aligning with the guiding principles for sustainable development.

Targets

This framework charts the way to achieving the targets[1] envisaged in the forthcoming *Action plan (2022–2030) to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority*, including a 20% relative reduction in the harmful use of alcohol by 2025 in and across all Member States (WHO, 2022a). The framework will also support the realization of commitments made under the United Nations 2030 Agenda for Sustainable Development, including achievement of targets 3.4 and 3.5 of the Sustainable Development Goals, and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025.

Other more intermediary measures and milestones are being developed to track progress and to measure success, in line with those now in use, on the basis of data already collected by the WHO to avoid any additional reporting burden for the parties.

Scope

The framework will become the basis of a WHO European Region support package for Member States, with the intention to achieve the operational objectives, to share the operational principles and to prioritise areas of action, as laid out in the forthcoming *Action plan (2022–2030) to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority*[2]. It will include overall policy recommendations as well as recommendations for Member States and for the WHO Secretariat and will be linked to existing

[1] Appendix one summarises all of the targets.
[2] See Appendix one.

WHO European Region priorities and mechanisms of relevance to alcohol consumption, including (i) the SAFER WHO European Region free from harm due to alcohol initiative; (ii) the NCD Advisory Council's Signature Initiative on alcohol taxation; (iii) the pan-European movement United Action Against Cancer, and (iv) the EPW's Healthier behaviours: incorporating behavioural and cultural insights flagship initiative, which incorporates behavioural and cultural insights as well as health literacy.

The framework articulates an action-oriented approach, harnessing the momentum built through the WHO-led SAFER initiative (WHO, 2022b) and its engagement with several stakeholders, including non-State actors, and building on partnerships in other regions. WHO will work to strengthen the expertise and sharing of experience of Member States, NGOs, civil society colleagues, including people with lived experience, and academics, through the development of an action-based policy network, utilising WHO's national focal point network for alcohol policy and an international seminar programme. Using synergies in areas such as health taxes, labelling and restrictions of digital marketing, the framework addresses the gap between the potential of the EAPA and current achievements in different countries, and strikes a balance between recognizing the importance of a comprehensive and effective public health approach and driving forward key actions to improve implementation. These are organised into six focus areas, following the discussions of the final regional consultation of Member States on the EAPA, with areas one to three focusing on activities related to the NCD "Best Buys" (WHO, 2017a):

- Focus area one – Alcohol Pricing
- Focus area two – Alcohol Availability
- Focus area three – Alcohol Marketing
- Focus area four – Health Information
- Focus area five – Health Service Response
- Focus area six – Community Action

Focus areas

Focus area 1 – Alcohol Pricing

Background

The evidence is strong and consistent for links between the affordability of alcohol, how much is consumed and likely harms. The implementation of effective pricing policies is a WHO "Best Buy" and considered to be the most effective and cost-effective policy measure ((Chisholm et al., 2018; WHO, 2020c). Although there have been some positive developments, with several countries moving to implement Minimum Unit Pricing systems (MUP), only 15 Member States (28.3%) report regularly adjusting the level of excise duty in line with inflation, meaning that, for

the vast majority of countries, alcohol grows more affordable over time.

The implementation of pricing policies affects the interests of different stakeholders with competing interests, some of which are diametrically opposed to each other. These stakeholders include producers, manufacturers and retailers of alcohol; those who are responsible for alcohol pricing and tax policy; for licensing the production, distribution and sale of alcohol; for regulating and monitoring commercial communications on alcohol; and for identifying and stamping out illegally produced and traded alcohol.

Cross-border trade complicates tax considerations for some Member States. Although national health policies belong to the jurisdiction of Member States (Article 168 in the Treaty on the Functioning of the European Union), many of the issues cannot be solved at national level. Both EU countries and those outside the EU are exposed to cross-border issues, including on-line sales and travellers' allowances.

Increasing alcohol taxes contributes to state revenue, as well as reducing health and social harms. The setting of alcohol taxes and other pricing policies must be tailored to specific national contexts. From a health perspective a specific system of alcohol taxation should be in place in all countries, with higher rates of duty for stronger products. The effectiveness of all pricing policies relates to the affordability for all population groups at risk of harm and Member States need to monitor and periodically adjust rates as required (WHO, 2020c).

Tax increases do not necessarily result in higher prices at the point-of-sale, since producers, distributors and retailers may choose to adjust consumer prices to compensate for higher taxes. Sometimes alcoholic beverages are sold below cost unless that is prohibited by legislation. An effective way to remove the cheapest alcohol from the market is by introducing Minimum Pricing policies, which set a lowest price limit related to alcohol content, below which alcohol products cannot be sold. While taxation is a measure that targets the general population, MUP targets the cheapest alcohol products that are typically consumed by the heaviest drinkers; this is therefore an effective policy for reducing health inequalities. MUP ensures that the price increase is passed-on to consumers and it prevents 'trading down' to cheaper products as there is no alcohol available for less than the minimum price (WHO, 2020c).

Recommendations for Member States

- Revisit existing alcohol pricing policies to include: regular review of affordability (for the whole population and for specific groups); review of taxation levels in line with inflation

- Consider introducing additional pricing measures, including Minimum Unit Price (MUP); bans on below-cost selling or volume discounts; and special taxes for products that are especially attractive to young consumers

- Identify and engage focal points in Ministry of Health and Ministry of Finance to create a taskforce and plan intercountry capacity building activities and engage in intersectoral dialogue on alcohol pricing issues

- Establish platforms for transnational information gathering on the impact of different pricing policies on cross border trade, monitoring and exchanging the information with

customs, tax and other authorities

- Collaborate with neighbouring countries in order to minimise cross border issues
- Consider introducing a monitoring system for the whole supply chain to collect data on the volumes of production including raw materials and leftovers, as well as on imports and retail sale of alcoholic beverages
- Counteract illicit trade and production and sale of other types of unrecorded alcohol by establishing tracking systems with unique identifiers in retail sale contexts as well as revisiting existing regulatory frameworks on homemade production of alcohol.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Support Member States to assess the potential health impact of alcohol pricing policies for countries with diverse circumstances in the WHO European Region
- Support Ministries of Health in promoting an intersectoral approach for alcohol control so as to have a coherent whole-of-government approach to policy making
- Assist countries in identifying and overcoming barriers and provide technical assistance to Member States in relation to legislative approaches to pricing policies
- Facilitate capacity building for all relevant stakeholders through training and sharing of technical expertise (e.g. regular expert technical meetings)
- Enable multi-sectoral dialogues to address cross-border issues
- Support Member States with technical advice on introducing or improving mechanisms that will better monitor sales and consumption patterns, so that the information gathered can inform public health actions at governmental level.

Focus area 2 – Alcohol Availability

Background

Greater availability of alcohol is associated with higher levels of consumption and harms and reducing availability is another of WHO's "Best Buys" (Chisholm et al., 2018). Regulating availability includes paying attention to number or density of premises and hours or days of sale. Interventions to reduce harms include restricting times and days of sale, limiting the number of outlets and setting a minimum legal age limit for alcohol service on premises and sale of alcohol for consumption off premises. In digital contexts, strategies to reduce availability of alcohol need to adapt to the growth on several countries of online and telephone sales. In addition to reducing alcohol-related harms, implementation of these strategies comes with a low cost and they are therefore cost-effective.

The most widely used measure to restrict alcohol availability in the European Region is to set legal age limits for purchase or serving of alcoholic beverages. In these contexts, alcohol sales

are often also forbidden to persons being visibly intoxicated or suspected of buying alcohol on behalf of underage persons. On the other hand, restrictions on hours of sale are rare, with only 10% of countries reporting restricting hours of on-premises alcohol sales and 20% off-premises alcohol sales.

Regulations that restrict sales of alcohol to licensed outlets, including in some cases, government retail monopoly stores, are effective in reducing alcohol availability as infringements of the regulations can lead to revoking of licences. Alcohol availability is also reduced if bans are imposed on alcohol consumption in different places (such as parks, streets, hospitals and workplaces) or under specific circumstances (such as during football matches and music festivals). In 2016, complete or partial statutory bans were most commonly applied to educational buildings, followed by sporting events and health care buildings. Between 2012 and 2016, there was an increase in the use of statutory bans in health care facilities, in educational buildings, at workplaces, on public transport, at sporting events, in places of worship, and at leisure events. In 2016, 34 countries also reported restrictions on on-premises sales of alcohol to intoxicated persons.

As with other areas of intervention in consumer markets, the effectiveness of policies to restrict alcohol availability is influenced by having an effective legal system to monitor and enforce the implementation of regulations. Implementation of strategies should preferably be carried out in cooperation between national authorities, licensing officers, local governments such as city councils and the police. Availability restrictions also need to be supported by the general public and efforts need to be made to inform the citizens of the public health and social benefits.

Recommendations for Member States

- Prioritise within the national alcohol strategy principles and policies to manage alcohol availability in order to reduce alcohol consumption and harms, with measurable outcomes and adequate support for enforcement. The framework should aim to establish consistent practices across Member States, including:
    - Support for establishment and/or improvement of national licensing systems, so as to provide support for local licensing decisions, with effective sanctions, including the ability to refuse to grant licences where it can reasonably be assessed that their provision will impact negatively on public health and social functioning
    - Implementation of minimum age guidance for sale, possession and consumption of alcohol; consideration of enforcement of total restrictions on alcohol sales in and around sporting events and any cultural events which include minors
    - Actions to mandate server and salesperson training for all alcohol outlets; to restrict the number and density of outlets, days and hours of sale; and to regulate drinking in outdoor public spaces, where this is permitted

- Consideration of implementing restrictions on alcohol sales/consumption within transport settings, including in transport terminals, on aircraft, in passenger trains and on sea-going vessels
- Plans to anticipate and respond to new modes of alcohol delivery, such as telephone and online sales, with commitment to introduce new regulations to restrict availability in these contexts as required
- Data gathering on enforcement of different availability measures and ways to improve this, as well as on economic and social impacts of measures to reduce alcohol availability.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Document and disseminate best practice examples of regulating alcohol availability including emerging forms of availability, such as telephone and online sales of alcoholic beverages
- Promote the exchange of country experiences on the most effective administrative and legislative approaches to regulating the availability of alcohol.

Focus area 3 – Alcohol Marketing

Background

Restricting marketing of alcohol is a third WHO recommended "Best Buy" – a cost-effective alcohol policy to reduce alcohol consumption and attributable burden, with clear evidence that this is an effective way of reducing alcohol-related harms (Chisholm et al., 2018). Marketing strategies include not only advertising and promotional activities, but also product development, price-setting, distribution, sponsorships and the targeting and segmentation of the market with different products. Traditional methods of alcohol marketing, using broadcast media (such as television and radio) and non-broadcast media (such as print media, billboards and branded merchandise) are increasingly being replaced by digital/online marketing.

There is a strong association between levels of exposure to alcohol marketing, impacts on alcohol consumption levels and harms, with risks of harm especially, though not only, for young people (WHO, 2020d). Exposure to alcohol advertising makes it more likely that children and young people will begin alcohol consumption at an early age, as well as that they will drink more frequently and with drinking patterns that present more risks of harms to their health (WHO, 2021b). Marketing in online contexts presents special risks for young people (WHO, 2021b). In many countries across the WHO European Region, up to 92% of those who use the access the Internet every day are aged between 16 and 19 years (WHO, 2020d).

The fact that digital marketing operates beyond country borders means that consumers can access global content but the responsibility for regulation does not sit rigidly within one country; also, different countries have different regulations, so there is a lack of consistency at

international policy level (WHO, 2021b). With social media and other online apps, marketer-generated and user-generated content blur the boundaries between advertiser and consumer, with internet users, often unknowingly, effectively becoming marketers of alcohol and other harmful products through their online activities (WHO, 2021b). Existing regulations may be inadequate as they tend to focus on volume, placement and content, whereas in digital contexts it is "predatory" data-driven models of profiling and targeting that seek to optimize attention and consumption (Carah and Brodmerkel, 2021). The digital context also presents challenges in considering interventions into what is deemed to be private content and communication sharing and consensual engagement. However, even within contexts of such indirect marketing, there are adjustments that could be made, either voluntarily by actions of the platform providers or enforced by legislation (WHO, 2021b).

The interplay between the digital marketing ecosystem and global platforms needs to be mapped and understood by policy-makers at local, national and international levels, with regulatory systems being established across borders and across platforms that can move quickly to protect public health and consumer rights. To support Member States, WHO's CLICK framework (WHO, 2019c) supports monitoring of digital marketing of unhealthy products to children; the resulting tool is flexible and can be adapted to national contexts. The tool's use can be expanded to alcohol contexts, including exploring the expansion of the target groups that would benefit.

The United Nations Convention on the Rights of the Child (United Nations, 1989) proclaims the right to health. This includes that children should be protected from exploitative marketing that can harm their health and well-being. Alcohol marketing fits clearly within this frame. Member States of the WHO European Region and the WHO–UNICEF– Lancet Commission have made clear their belief that self-regulation is insufficient to offer the protections that are needed (WHO, 2020e; WHO–UNICEF–Lancet Commission, 2020). Just as with tobacco, a global and comprehensive approach is required to remove alcohol marketing as far as possible, from all contexts. The more comprehensive the alcohol control policies, the easier it will be to ensure clarity in communication and interpretation of the legal intention, as well as actions to monitor and enforce regulations.

Recommendations for Member States

- Promote the creation of multi-sectoral working groups in order to find best ways to tackle traditional and digital marketing
- In countries where total bans are not in place, ensure that monitoring of alcohol marketing practices become the responsibility of an independent body or government agency, performed systematically and routinely, with no influence or interference from economic interests, and with effective monitoring and enforcement systems in place
- Undertake a thorough review and analysis of existing systems to streamline them, to implement changes that make them more effective in controlling content and volume of

exposure, and to strengthen monitoring and enforcement - such a review should also ensure that no alcohol marketing practices, including digital marketing activities, fall outside the control of regulatory systems and thus go unregulated

- Plan to restrict the content and volume of commercial alcohol communications, for example by limiting messages and images to factual content, without links to celebrities, such as influencers, or by banning all communications in the primary media of television, radio, films and sports sponsorships - regulatory codes could usefully state what is permitted, rather than what is not, with the legal presumption that what is not named is not allowed

- Build relationships with internet platform companies to encourage them to develop policies and use technologies which can measure, control and restrict alcohol marketing, including that to which minors are likely to be exposed, compelling them by regulation to act where voluntary schemes have not been effective

- Consider obliging alcohol companies to share their market data on consumers in different media, so that health ministries can have access to data sources indicating at scale what kinds of content are being circulated and how targeting of populations and individuals happens

- Build partnerships and collaboration with other countries and with international agencies in order to minimise cross border issues, with an intention, where possible of having transnational regulations and cooperation on monitoring and enforcement

- Consider how to introduce and implement new taxation systems, including e-commerce taxes, that can be used to limit marketing of alcohol. Also ensure that alcohol marketing activities are not considered as part of the cost of doing business, thereby reducing tax liabilities.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Document and disseminate best practice examples of how restrictions on alcohol marketing can be implemented with the outcome of reducing alcohol-related harms, including administrative and legislative approaches
- Develop and disseminate guidance to increase understanding of how digital marketing is used in relation to alcohol and policy options to reduce alcohol-related harms
- Promote the exchange of country and cross-national experiences relating to administrative and legislative approaches, including the development of an action-driven expert network to share information, assess likely future developments and to develop strategies to prioritise public health strategies

- Support intersectoral policy dialogues and policy briefs on the different components of digital marketing, as well as strategies to reduce risks of harm
- Pilot WHO's CLICK methodology (WHO, 2019c) with Member States, supporting the development of a framework to monitor digital marketing of unhealthy products, including alcohol, to children and others at risk of harm due to alcohol marketing
- Work with other United Nations agencies, including the United Nations Children's Fund (UNICEF), to establish discussions with major platforms about the prevention of exposure of children, young people and vulnerable adults to alcohol marketing in online contexts
- Encourage the development of new national and transnational regulatory and monitoring approaches, as well as disseminating evidence about possible technological and policy gaps and likely effective policy approaches.

Focus area 4 – Health Information

Background

Consumers have the right to be able to access accurate information to enable them to make informed choices about the products they consume, and it is the obligation of governments to ensure consumers are provided with this information. There is substantial interest by Member States on improving policy implementation on the provision of health information using labels. While labelling of foodstuff and non-alcoholic beverages is relatively well regulated across the WHO European region, labelling of alcoholic beverages is an area that has received little attention so far.

Overall, 21 Member States (40%) have some legislation on the listing of ingredients, ten (19%) have some legislation on inclusion of nutritional values and 15 (28%) have some legislation on health warnings. However, with regard to health warnings, only nine countries (17%) have legislation specifying the size and content of the message (WHO, 2020f).

Public awareness of the range of harms associated with alcohol consumption is low. Many people are unaware of the risks of developing a range of cancers due to alcohol consumption, even at very low levels. As well as this, fetal development can be affected by drinking in pregnancy, leading to lifelong developmental and learning difficulties for children. The provision of labelling that increases knowledge of the risks associated with alcohol consumption may lead to an increase in public support for other policy measures to reduce alcohol-related harms, even where these might be perceived as intervening in consumer contexts which have previously been less regulated, such as pricing policies and marketing restrictions.

The WHO European region has seen some progress on calls for nutritional and ingredients information as well as health warning labels. The Eurasian Economic Union Technical Regulation

047/2018 “On safety of alcoholic beverages” is, to date, the only international document to impose binding provisions on alcohol labelling. The regulation applies to all types of alcoholic beverages intended for human use in the territory of the EAEU member states, i.e. Armenia, Belarus, Kazakhstan, Kyrgyzstan and the Russian Federation (Neufeld and Rehm, 2020). At the EU-level, in ‘Europe's Beating Cancer Plan’ the European Commission indicated that it will review its promotion policy on alcoholic beverages. The European Commission also initially indicated a proposed mandatory indication of the list of ingredients and the nutrition declaration on alcoholic beverage labels before the end of 2022 and of health warnings on labels before the end of 2023 (European Commission, 2021).

A systematic search for alcohol labelling information across the WHO European Region as part of a synthesis report of the WHO Health Evidence Network revealed that, in 2019, the provision of alcohol labelling generally, and health warnings specifically, was not mandatory in many countries in the Region (WHO, 2020f). WHO proposes that measures should be taken to mandate the provision of health and nutritional information and lists of ingredients on all alcoholic beverage containers, as a complementary part of an overall policy approach to reducing alcohol-attributable harms. This policy should be supplemented by an integrated communication strategy that includes point-of-sale information, and package inserts, as well as broader communication activities, including social norm campaigns. Once phased in, such an initiative costs very little, and at the very least warning labels can remind consumers, and society at large, that alcohol is no ordinary commodity.

Recommendations for Member States

- Ensure that national health ministries establish arrangements for independent mandating, monitoring and enforcement of what appears on all alcohol labels, working in the interests of public health and consumer rights and free from influence or interference from corporate interests
- Statutory labelling requirements should be guided by the considerations and best practice laid out in WHO/Euro’s recent review of alcohol labelling *WHO Health Evidence Network Synthesis Report 68* (WHO, 2020f) - in particular, label content and design should be specified, according to evidence of effectiveness of: messaging; presentation (size, colour, etc.); and positioning on the container. Content should include nutrition and ingredient labelling as well as health warning labels, based on recommendations in WHO’s *Alcohol labelling – A discussion document on policy options* (WHO, 2017b)
- If Member States assess that in their contexts self-regulation of labelling is easier to implement, they should at least require alcohol producers to demonstrate that they have sought and followed the advice of independent and nationally recognised public health agencies
- Invest in and promote more detailed information on the effects of health warning labels, by means of geographically stepwise introduction that enables measurements of the effects on public knowledge, awareness, and drinking intentions

- Consider advancing the core principle of a 'Right to Know' for consumers as a statutory right for all citizens.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Promote the exchange of country experiences relating to administrative and legislative approaches on labelling

- Use the expertise and knowledge of the WHO Behavioural and Cultural Insights flagship initiative to develop guidance for alcohol labelling provisions, including nutritional information and health messages, and specifically cancer warnings.

Focus area 5 – Health Service response

Background

The health sector provides a vital front line in prevention and early intervention to reduce alcohol-related harms, as well as facilitating comprehensive support, wherever needed, to support individuals to recover, as well as their families. Health service actions need to be aligned with community action in identifying risky drinking behaviours, providing early interventions before health and social problems become pronounced and severe forms of alcohol use disorders develop that require specialised medical care, as well as ensuring that specialised services are available for people with alcohol use disorders.

Health services need to be holistic, learning from people with lived experience and, where appropriate, including families as part of the recovery process, as well as engaging with external services, including mutual aid organisations to support long-term recovery. Where possible, support services should be put in place to support children and families affected by another person's drinking.

Evidence strongly supports the widespread implementation of screening and brief intervention programmes in primary care settings for individuals with hazardous and harmful alcohol consumption (WHO, 2017c). There is also some evidence that similar programmes implemented in accident and emergency departments as well as other specialised settings can be effective. In 2016, only 30 countries reported having clinical guidelines for screening and brief interventions that had been approved or endorsed by at least one health care professional body. Estimated coverage was low, with only 15% of countries reporting coverage of more than 31% of the population for routine screening and brief interventions. Primary care providers find it easier to undertake this intervention when they are supported by specialist services to which they can refer.

As a rule, alcohol use disorders should be considered primarily as health problems and people with these problems should be cared for as part of the healthcare system. People with alcohol-related problems are often grappling with many other health-related issues. For example, many people with alcohol problems face mental health issues, and many people with mental health issues have alcohol problems, yet services still find it difficult to treat their co-occurrence effectively.

This Framework encourages Member States to be aspirational, recognising that national or local treatment services or systems will be at different stages of development and with differing resources to support them but that over time, progressive quality improvement, with evidence-based and ethical practice as an objective, can and should be expected to achieve better organised, more effective and ethical systems and services for people with alcohol-related problems (as with WHO and UNODC, 2020). Recovery oriented systems of care (ROSC) constitute an approach to the long-term management of patients within the network of community-based support resources and services. Professionally directed recovery management, as with the management of other chronic health disorders, shifts the focus of treatment from one that seeks to "admit, treat and discharge" to a sustained health management partnership between services and the patient. In this model, post-stabilization monitoring, recovery education, recovery coaching, active linkage to recovery communities (including 12-step peer support), resource development and rapid access back to treatment, when needed, take the place of the traditional discharge process (as with WHO and UNODC, 2020). Processes should be person-centred and rights-based. Evidence-based bio-medical interventions should combine with psychosocial interventions in a flexible manner, according to the needs of patients. Health service staff should aim to build therapeutic relationships with patients and working relationships with colleagues and people with lived experience of alcohol problems to co-produce plans and embed actions that support recovery over the long term for drinkers and their families. This is similar to the system of care for patients with other chronic diseases (such as diabetes, asthma and cardiovascular diseases and drug use disorders).

Addressing harms due to alcohol consumption exerts considerable financial pressures on social and health care systems, which are often very stretched. These pressures have been exacerbated by the COVID-19 crisis. Emerging evidence (Wang et al., 2021) suggests that people with alcohol use disorders may be at increased risk of infection from the virus, as chronic alcohol consumption affects all aspects of immunity.

Recommendations for Member States

- National guidance should be developed or revised where it already exists to combine biopsychosocial treatment strategies with community support for patients over the long term, maintaining contact, offering crisis interventions and support when needed and at different levels of intensity and with active linkage to recovery communities (including 12-step peer support)
- Expand provision of alcohol-related screening and brief interventions in primary healthcare settings, with expansion into other contexts based on evidence

- Ensure adequate provision of psychosocial treatment and pharmacological treatments where these are required
- Support all alcohol-related services with national clinical guidelines and a rigorous evaluation structure, paying attention to processes, outputs and outcomes, with services regularly reviewed and adapted according to findings
- Ensure that integrated responses to prevent and reduce harm due to alcohol take into consideration the need to reduce harm to others, including families and through FASD.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Support countries to build their capacity to continue providing essential alcohol-related health and care services alongside emergency response measures in the case of future health emergencies
- Support countries in developing, adapting and validation instruments and practical materials to facilitate implementation of screening and brief interventions in different contexts
- Use the synergies of two other WHO flagship initiatives, *The Pan-European Mental Health Coalition* and *Empowerment through Digital Health* to expand provision of guidance and support for implementation of evidence-based screening and brief interventions in primary healthcare, the workplace and social services, taking into consideration the specificities and differences in health and social systems across the region
- Extend opportunities for information and experience sharing between countries where screening and brief interventions has been/is being implemented and countries where this has not yet been realised.

Focus area 6 – Community Action

Background

Alcohol consumption has harmful consequences to which entire communities must respond. As well as the immediate harms to health and social functioning of individuals, their families and friends, communities must deal with injuries and deaths from road traffic accidents, provide hospital and emergency medical services and provide interventions for alcohol use and alcohol dependence.

People with alcohol problems and their families are part of communities. The lived experience that they have can help to inform strategies to prevent alcohol problems and to support recovery. Non-state actors, including NGOs and recovery activists, mutual aid and self-help organisations, possess expertise, experience and connections that can inform strategies to support recovery, often at insignificant cost to the state, and they should be regarded as essential partners in developing and implementing national and local alcohol plans. People recover when they are happy and fulfilled and able to contribute to society. Working within communities can help to reduce the stigma associated with having an alcohol problem, which can present barriers for individuals and families to seek support, as well as leading to discrimination in the workplace and other settings. Evidence also supports policies to reduce structural inequalities in society as contributing to preventing and reducing alcohol-related harms.

Local communities can help to create and sustain healthy living environments. Communities can be encouraged to mobilise public opinion to address local determinants of increased alcohol consumption and alcohol problems – for instance by countering the attractiveness of the image of people drinking and of any acceptable level of drinking associated with driving; reducing unfair privileges attached to alcohol use; improving recognition of the nature and magnitude of the health and social consequences of harmful use; identifying and countering the influences that encourage increased alcohol consumption; reducing the risk of young people developing social norms that always include alcohol consumption; encouraging people to stop drinking, reduce their use or reduce harmful patterns of consumption; countering violence and aggression related to alcohol. Community organisations can help to improve health literacy across populations, including providing information about where to obtain help and support in relation to alcohol problems. Community groups are often well placed to inform local decisions that affect their alcohol environments, such as advising on or even making licensing decisions, based on public health considerations. They can also be effective advocates for the implementation of effective alcohol policies, including with media and policy makers.

Community-based intervention projects involving stakeholders exist in 43 Member States and twenty-two countries have national guidelines for the prevention of and counselling for alcohol problems in the workplace. However, the level of health literacy remains low in various communities, especially in relation to alcohol harms and the continuum of alcohol-related risks. Public levels of awareness of links between alcohol consumption and cancer remain low and, despite evidence to the contrary, two thirds of EU citizens believe that higher alcohol prices will not discourage young people and heavy drinkers from consuming alcohol. This finding suggests that focusing on alcohol affordability in public education campaigns would obtain stronger public support for higher alcohol taxes.

School and community interventions may usefully be combined, in part because community efforts can help restrict young people's access to alcohol. There is an increasing body of evidence that demonstrates positive outcomes from prevention activities in schools, especially where these also engage families and communities. School-based programmes should be part of a holistic approach of a health-promoting school. They should be based on educational

practices that have proven effective, e.g. by targeting important transition periods, conducting systematic needs assessment, ensuring an interactive approach based on skills development and embedding evaluation throughout. Alcohol education and information programmes should be developed, delivered and evaluated without any involvement or influence from economic operators (WHO, 2009).

Recommendations for Member States

- Consider introducing and/or implementing legislation that empowers local communities to inform and/or make local decisions that affect their alcohol environments, such as enabling them to influence licensing decisions, based on public health considerations

- Support the development of evidence-based schools, community and workplace programmes on alcohol, including allocating resources for evaluation and adaptation of activities in response to findings

- Align national and local strategies so that community resources, including professional organisations, NGOs, mutual aid or peer support agencies including people with lived experience of alcohol problems, faith-based organisations and schools and other educational institutions can contribute to the recovery of individuals, families and communities.

Actions for the WHO Regional Office for Europe (WHO/Euro)

- Expand platforms for NGOs, civil society organisations, including those that include people with lived experience, and academics to improve health literacy and public knowledge about alcohol consumption and harms and to build advocacy capacity for policies to reduce alcohol-attributable harms

- Extend opportunities for information and experience sharing about effective and cost-effective community and workplace-based strategies and interventions have been/are being implemented and countries where this has not yet been realised

- Promote awareness of national and international initiatives that empower communities to make decisions in relation to local alcohol policies

- Make available evidence about alcohol consumption and harms that can counter arguments and interferences from the alcohol industry, for example, when they sponsor community or sporting events as part of CSR (Corporate Social Responsibility) activities.

Appendix one: Draft Action Plan (2022-2030) to effectively implement the Global Strategy to reduce the harmful use of alcohol as a Public Health priority – key areas (WHO, 2022)

Operational objectives

1. Increase population coverage, implementation and enforcement of high-impact policy options and interventions to reduce the harmful use of alcohol worldwide for better health and well-being, taking into account gender perspective and a life-course approach.

2. Strengthen multisectoral action through effective governance, enhanced political commitment, leadership, dialogue and coordination of multisectoral action.

3. Enhance the prevention and treatment capacity of health and social care systems for disorders due to alcohol use and associated health conditions as an integral part of universal health coverage and aligned with the 2030 Agenda and its health targets.

4. Raise awareness of the risks and harms associated with alcohol consumption and its impact on the health and well-being of individuals, families, communities and nations, as well as of the effectiveness of different policy options for reducing consumption and related harm.

5. Strengthen information systems and research for monitoring alcohol consumption, alcohol-related harm, their determinants and modifying factors, and policy responses at all levels, with dissemination and application of information for advocacy in order to inform policy and intervention development and evaluation.

6. Significantly increase the mobilization of resources required for appropriate and sustained action to reduce the harmful use of alcohol at all levels.

Operational principles

Multisectoral action. The development, implementation and enforcement of alcohol control policies at all levels require concerted multisectoral action, with the engagement of the health sector and other relevant sectors, such as social welfare and employment, customs, agriculture, education, transport, sport, culture, finance and law enforcement, as appropriate, to address the harmful use of alcohol in their activities.

Universal health coverage. All individuals and communities, including those in rural areas, receive the health services they need, without suffering financial hardship, to reduce the health burden caused by the harmful use of alcohol, including the full spectrum of essential quality health services, from health promotion to prevention, treatment, rehabilitation and palliative care across the life course.

Life-course approach. Recognizing the importance and interrelationship of alcohol control measures and prevention and treatment strategies and interventions to prevent and reduce alcohol-related harm at all stages of a person's life and for all generations. This ranges from eliminating the marketing, advertising and

sale of alcoholic products to minors and the protection of the unborn child from prenatal alcohol exposure to the prevention and management of the harms due to the use of alcohol in older people.

Protection from commercial interests. The development of public policies to reduce the harmful use of alcohol should be protected, in accordance with national laws, from commercial and other vested interests that can interfere with and undermine public health objectives.

Equity-based approach. Public health policies and interventions to reduce the harmful use of alcohol should aimed to reduce health inequalities and protect people in different groups (across social, biological, economical, demographical or geographical divides) from alcohol-related harm.

Human rights approach. Protection from alcohol-related harm and access to the prevention and treatment of AUDs in health systems contributes to the fulfilment of the right to the highest attainable standard of health; strategies and interventions to reduce the harmful use of alcohol should address and eliminate discriminatory practices (both real and perceived) and stigma with regard to preventive measures and health and social services for people with AUDs.

Empowering of people and communities. The development and implementation of strategies and interventions to reduce the harmful use of alcohol and protect people and communities from alcohol-related harm should provide opportunities for the active engagement and empowerment of people and communities, including people with lived experiences of alcohol-related harm or AUDs.

Key areas for global action

Action area 1: Implementation of high-impact strategies and interventions

Action area 2: Advocacy, awareness and commitment

Action area 3: Partnership, dialogue and coordination

Action area 4: Technical support and capacity-building

Action area 5: Knowledge production and information systems

Action area 6: Resource mobilization

Global targets

Action area 1

Global target 1.1: By 2030, at least a 20% relative reduction (in comparison with 2010) in the harmful use of alcohol.

Global target 1.2: By 2030, 70% of countries have introduced, enacted or maintained the implementation of high-impact policy options and interventions.

Action area 2

Global target 2.1: By 2030, 75% of countries have developed and enacted national written alcohol policies.

Global target 2.2: By 2030, 50% of countries have produced periodic national reports on alcohol consumption and alcohol-related harm.

Action area 3

Global target 3.1: By 2030, 50% of countries have an established national multisectoral coordination mechanism for the implementation and strengthening of national multisectoral alcohol policy responses.

Global target 3.2: By 2030, 50% of countries are engaged in the work of the global and regional networks of WHO national counterparts for international dialogue and coordination on reducing the harmful use of alcohol.

Action area 4

Global target 4.1: By 2030, 50% of countries have a strengthened capacity for the implementation of effective strategies and interventions to reduce the harmful use of alcohol at national level.

Global target 4.2: By 2030, 50% of countries have a strengthened capacity in health services to provide prevention and treatment interventions for health conditions due to alcohol use in line with the principles of universal health coverage.

Action area 5

Global target 5.1: By 2030, 75% of countries have national data generated and regularly reported on alcohol consumption, alcohol-related harm and implementation of alcohol control measures.

Global target 5.2: By 2030, 50% of countries have national data generated and regularly reported on monitoring progress towards the attainment of universal health coverage for AUDs and major health conditions due to alcohol use.

Action area 6

Global target 6.1: At least 50% of countries have dedicated resources for reducing the harmful use of alcohol by implementing alcohol policies and by increasing coverage and quality of prevention and treatment interventions for disorders due to alcohol use and associated health conditions.

Appendix Two: How WHO/Euro will measure progress

At the overarching level, this framework aligns with the WHO General Programme of Work (GPW 13) Impact Framework and specifically with GPW Outcome 4:

- Noncommunicable diseases prevented, treated, managed, and their risk factors controlled, and mental health prioritized and improved.[3] (WHO, 2019d)

The framework will support the realization of commitments made under the United Nations 2030 Agenda for Sustainable Development, including achievement of targets 3.4 and 3.5 of the Sustainable Development Goals, and the Action Plan for the Prevention and Control of Noncommunicable Diseases in the WHO European Region 2016–2025. It will also align with the targets[4] set by the forthcoming *Global Alcohol Action Plan (2022–2030) to strengthen implementation of the Global Strategy to Reduce the Harmful Use of Alcohol as a Public Health priority* (WHO, 2022a), which will be considered by the Seventy-fifth World Health Assembly in May 2022, following the 150th session of the WHO Executive Board in January 2022. WHO/Euro will establish monitoring arrangements that will measure both overall alcohol per capita consumption in the national context within a calendar year in litres of pure alcohol and the extent to which recommended alcohol control policies laid out as priorities in this Framework have been implemented by Member States (Table 1).

WHO /Euro will work to ensure that the evidence gathered is as robust as possible. Tools used for measuring implementation progress will include the WHO Alcohol Policy Scoring Tool (WHO, 2017d), and its indicators for measuring alcohol policy implementation. Additional summary indicators are suggested to be included in this Framework. A summary report on the implementation progress will be produced for the period 2022-25.

[3] Also within GPW 13, within the 'Triple Billion' goal for 'Healthier populations', there are five Platform Initiatives intended to achieve the outcome of one billion more people enjoying better health and well-being. Platform Two focusses on 'Accelerating action on preventing noncommunicable diseases and promoting mental health'. This includes: 'interventions to reduce…harmful use of alcohol' and a commitment to provide evidence-based guidance to 'reduce…the harmful use of alcohol' and 'to stop the marketing of unhealthy…beverages to children' as well as 'technical assistance and evidence-based guidance to countries on the "best buys" and other recommended interventions for prevention and treatment of NCDs'.

[4] Also see Appendix one.

Table 1: Summary Indicators to measure implementation progress of the *Framework to strengthen implementation of the WHO European Action Plan to Reduce the Harmful Use of Alcohol (EAPA), 2022 – 2025*

Policy area	Proposed Summary Indicators (SIs)	Definition of Summary Indicator (SI)	Relevant Indicators that are already included in the EAPA scoring tool
Pricing policies	Affordability of alcoholic beverages	Affordability: Gross Domestic Product based on Purchasing Power Parity (GDP PPP) per capita divided by the price of 10 g pure alcohol (standard drink), weighted by the share of each beverage type (beer, wine, spirits) in total consumption. Data for this summary indicator requires information on; - GDP PPP - Average price of beer, wine and sprits - Alcohol per capita consumption per beverage type	Adjustment of excise duty tax of alcoholic beverages for inflation Calculation of excise duty tax by volume/weight
	Alcohol tax share	Tax share: the proportion of excise tax in the final off-premises retail prices of beer, wine and spirits	Excise duty per hectolitre
Availability of alcohol	Restrictions on availability by time	Number of hours during which off-premises alcohol sales are allowed (working days) Number of hours during which alcohol off-premises sales are allowed (Saturdays) Number of hours during which off-premises alcohol sales are allowed (Sundays) Number of hours during which off-premises alcohol sales are allowed (Holidays) Number of holidays during which off-premises alcohol sales are allowed (Holidays)	Restrictions on times of on- and off-premise sales of alcoholic beverages Restrictions on locations of on- and off-premise sales of alcoholic beverages Restrictions on off premise sales of alcoholic beverages at petrol stations
	Restrictions on availability by place	Are there any restrictions by density of sale outlets by location? (on and off premises) Are there any restrictions by location of sale outlets by location? (on and off premises) Are there bans on alcohol consumption in the following public environments	Restrictions on on- and off-premise sales of alcoholic beverages during specific events

	Alcohol-free public environments	• Public transport • Parks, streets • Sporting events • Workplaces	
Marketing of alcoholic beverages	Legally binding bans of alcohol marketing on the internet/social media Legally binding bans on industry sponsorship for sporting and youth events	Legally binding bans on alcohol advertising through the Internet Legally binding bans on alcohol advertising through social media Legally binding bans of industry sponsorship of sporting events Legally binding bans of industry sponsorship of youth events	Restrictions on alcohol advertising Level of enforcement of advertising restrictions Penalties for violations of advertising Restrictions on sponsorship by the alcohol industry Level of restriction on alcohol industry sponsorship and alcohol sales promotion Level of enforcement of alcoholic beverage industry sponsorship restrictions Penalties for violations of sponsorship and sales promotion legislation Level of restriction on alcohol advertising/product placement
Reducing the negative consequences of drinking	Health warning labels	National legal requirements of health warnings on the containers/bottles of alcoholic beverages (separately for beer, wine, spirits) regarding	Health warning labels on alcohol advertising Health warning labels

and alcohol intoxication – specific to labelling	Consumer information labelling (nutritional and caloric)	• Overall health • Cancer • Pregnancy • Underage drinking • Drink-driving • Other [specify the text(s) of the legally required health warning labels] National legal requirement to display consumer information (separately for beer, wine, spirits) about • Calories • Additives • Vitamins • Alcohol content • Number of standard drinks • National drinking guidelines (if in place)	on alcohol containers Product labelling on alcohol products
Health services' response	Screening and brief interventions (SBIs) for hazardous alcohol use and alcohol use disorders in primary healthcare settings	Guidelines and legal frameworks for providing SBIs in primary healthcare exists SBI training for primary healthcare workers exists and is carried out regularly Tools and materials for providing SBIs in primary healthcare in national language exist and were appropriately adapted and/or validated SBIs are provided in primary healthcare services	Brief interventions for health promotion/disease prevention Training in screening and brief interventions for alcohol problems Clinical guidelines for brief interventions Counselling for pregnant women with alcohol problems Persons with alcohol use disorders receiving treatment Prenatal care for pregnant women with alcohol or drug problems Counselling for children in families with alcohol problems
Community and workplace	School-based prevention and reduction of	National guidelines for prevention and reduction of alcohol consumption and harm in school settings	Educational programmes involving target groups in the

action	alcohol-related harm Workplace-based alcohol problem prevention and counselling Community-based interventions to reduce alcohol-related harm	National guidelines for prevention and reduction of alcohol consumption and harm in work settings National legislation for counselling and SBIs in workplace settings National legislation for alcohol testing in workplace settings National government support for community action to reduce alcohol consumption and harms through earmarked funds for community action Provision of technical tools tailored to communities (e.g., assessment tools) Training programmes in the community (e.g., adult and youth leadership) Community programmes and policies (e.g., after-school programmes) Community programmes for subgroups at particular risk (e.g., indigenous peoples, special needs groups) Provision of information to support community action Data dissemination in the community Research studies in the community	school curriculum Legal obligation to include alcohol prevention in the school curriculum/health policies Guidelines for prevention/reduction of alcohol-related harm in schools Prevention/counselling at workplaces for persons with alcohol problems Workplace accidents involving alcohol Involvement of social partners in prevention of alcohol-related harm at workplaces National guidelines for alcohol prevention/counselling at workplaces Legislation on alcohol testing at workplaces Strength of action in the policy area of alcohol issues at workplaces Community-based interventions/projects involving stakeholders National guidelines for community-based interventions to reduce alcohol-related harm

			Strength of action in the policy area of community action to reduce alcohol related harm

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The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe (WHO/Euro) is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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Georgia
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Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
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World Health Organization
Regional Office for Europe

UN City, Marmorvej 51,
DK-2100 Copenhagen Ø,
Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
Email: eurocontact@who.int
Website: www.euro.who.int